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OVERSIGHT INITIATIVE REPORT

FROM THE

SUBCOMMITTEE ON OVERSIGHT

ERRONEOUS PAYMENTS UNDER THE MEDICARE SECONDARY PAYER PROGRAM

INCLUDING RECOMMENDATIONS AND FINDINGS OF THE SUBCOMMITTEE

Report No. 2

JUNE 5, 1991

Prepared for the use of the Committee on Ways and Means by its staff

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LETTER OF TRANSMITTAL

COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON OVERSIGHT,
Washington, D.C., June 5, 1991.

The Honorable DAN ROSTENKOWSKI,
Chairman, Committee on Ways and Means,
U.S. House of Representatives, Washington, D.C.

DEAR CHAIRMAN ROSTENKOWSKI: We are submitting to the Committee on Ways and Means the report of the Subcommittee on Oversight on erroneous Medicare payments. This report was approved by the Subcommittee on a bipartisan basis on June 5, 1991, and is the result of the Subcommittee's investigation and hearing on the Medicare Secondary Payer program. We respectfully request that the Committee on Ways and Means review the Subcommittee's report and take action on the Subcommittee's recommendations in a timely manner. The attached report provides a brief background on the issue reviewed, the scope of the Subcommittee's investigation and hearing, and the Subcommittee's recommendations for administrative and legislative changes.

Since 1980, Congress has passed a series of laws increasing the situations in which private insurers must pay medical claims before Medicare. These provisions, setting forth the payment responsibility of private insurers, are known as the Medicare Secondary Payer (MSP) provisions. The implementation of the MSP provisions and the extent of erroneous Medicare payments were the subject of a hearing by the Subcommittee on Oversight on February 26, 1991.

The Subcommittee initially became interested in the MSP program because it was identified by the General Accounting Office (GAO) as a "high risk area." In addition, the Department of Health and Human Services (HHS) has listed the MSP provisions as a material internal control weakness under the Federal Managers' Financial Integrity Act, and estimated that as much as $1 billion may be lost annually because of erroneous Medicare payments, which under the MSP provisions, should have been paid by private insurers. In January 1991, the GAO issued a report on payments made by the Maryland Medicare contractor for which another insurer had been identified as having primary payment responsibility. The GAO found that there were some $8 million in claims to be recovered, but that the contractor was doing little to recover the erroneous payments.

The Subcommittee found that the situation in Maryland was symptomatic of a nationwide problem. That is, we believe that Medicare contractors have made hundreds of millions of dollars in payments that should have been made by another insurer. Little,

however, is being done to recover these payments. The full extent of this problem, nationwide, is unknown because Medicare contractors are not required to keep records regarding their efforts to recover payments identified as erroneous.

The problem of contractor backlogs of unrecovered erroneous payments will be exacerbated later this year. The Omnibus Budget Reconciliation Act of 1989 requires a data match of records of the Internal Revenue Service, Social Security Administration, and Health Care Financing Administration. The purpose of this data match is to identify Medicare beneficiaries who were employed or who had an employed spouse. With this information, employers will be contacted to determine if the Medicare beneficiary (or spouse) had health insurance. Then, with information about employment and health insurance, Medicare contractors will search their records to identify and recover erroneous payments. It is expected that the data match will identify a significant number of additional erroneous payments.

The Subcommittee believes that Medicare contractors should revamp the way they implement the MSP program. Heretofore, contractors have relied on a process called "first-claim development," whereby they contact beneficiaries upon the payment of the first Medicare claim to identify those covered by an employer group health plan. The Subcommittee believes that this process is inefficient, as it targets all Medicare beneficiaries, even though only about five percent are subject to the MSP provisions. More importantly, this process requires that contractors "pay and chase." That is, they pay the claim and then seek to recover if they subsequently learn that another payer is primary to Medicare. The Subcommittee recommends that: (1) Medicare beneficiaries should be screened regarding employer group health insurance coverage at the time of enrollment in the Medicare program; (2) that provider screening of beneficiaries should be improved; and, (3) that sanctions should be allowed against providers who routinely and willfully fail to screen beneficiaries for other insurance coverage.

The Subcommittee is concerned that Medicare contractors are not currently recovering erroneous payments, and will not be ready to undertake recovery efforts that will maximize the savings that could be realized from the data match. The Subcommittee believes that improvements are necessary in the manner in which Medicare contractors manage their recovery efforts. Specifically, the Subcommittee recommends: (1) that contractors should be required to submit quarterly reports to the Health Care Financing Administration on their efforts to recover erroneous payments; (2) that contractors should be evaluated on their recovery efforts; (3) that the recovery process should be streamlined; and, (4) that the Health Care Financing Administration develop and submit to the Committee an incentive program to encourage contractors to make additional recoveries of erroneous payments.

In addition, we believe that it is important that adequate funding be provided to Medicare contractors for MSP activities, which has a high cost/benefit ratio—approximately $30 to $1. Finally, the MSP provisions frequently require that the health insurance companies serving as Medicare contractors seek reimbursement from their private insurance operations. We are concerned that this situation

has created the appearance of a conflict of interest for the contractors. Accordingly, we recommend that a study be conducted to determine if eligibility as a Medicare contractor should continue to be restricted to health insurance companies.

The Subcommittee believes that the adoption of these recommendations will result in the prevention of erroneous Medicare payments and enhanced recovery efforts.

Sincerely,

RICHARD T. SCHULZE,
Ranking Minority Member.

J. J. PICKLE,
Chairman.

Attachment

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REPORT OF THE SUBCOMMITTEE ON OVERSIGHT ON ERRONEOUS PAYMENTS UNDER THE MEDICARE SECONDARY PAYER PROGRAM

BACKGROUND: THE MEDICARE SECONDARY PAYER (MSP) PROVISIONS

Medicare is a Federal health insurance program for people age 65 or older, certain younger disabled people, and people of any age with permanent kidney failure. It is administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (HHS). Medicare has two parts: hospital insurance (Part A), which helps pay for necessary care provided by Medicare-approved hospitals, skilled nursing facilities, home health agencies or hospice programs; and supplementary medical insurance (Part B), which helps pay for medically necessary physician services, outpatient hospital services, certain home health care, and various medical services and supplies not covered by Medicare hospital insurance. Hospital insurance (Part A) is financed through the Federal Insurance Contributions Act (FICA) tax paid by employees, employers, and the self-employed. Medical insurance (Part B), which is voluntary, is financed through monthly premiums paid by enrollees and from Federal general revenues.

After services or supplies have been supplied to a Medicare beneficiary, the provider (with the beneficiary) submits a Medicare claim. Claims are not processed by Federal employees. Rather, HCFA contracts with health insurance organizations around the country for the processing of claims. These contractors are referred to as "intermediaries" or "carriers." Intermediaries process hospital insurance (Part A) claims. Carriers process medical insurance (Part B) claims. For Part A claims, 47 contractors serve as intermediaries. Of this number, 41 are Blue Cross/Blue Shield organizations, and five are commercial insurers. For Part B claims, 34 contractors serve as carriers. Of this number, 26 are Blue Cross/Blue Shield organizations and eight are other commercial insurers.

Until 1980, the Medicare program was the primary payer of health care costs for beneficiaries, except when the beneficiary was covered by a workers' compensation program (including black lung benefits) or by the Veterans' Administration. Congressional concern about escalating increases in the cost of the Medicare program led to a series of seven statutory changes, beginning in 1980, that increased the situations in which private insurers must pay medical claims before Medicare. (See Attachment #1.) These rules are commonly referred to as the Medicare Secondary Payer (MSP) provisions. They shift, from Medicare to private-sector insurers and employers, the responsibility for paying medical claims for Medicare beneficiaries in certain situations where the beneficiaries have other health insurance.

The MSP provisions apply—that is, Medicare is secondary—in the following situations:

1. When an employed beneficiary has health insurance coverage through an employer group health plan, if the employer has 20 or more employees (For retired beneficiaries, even if covered by an employer group health plan, Medicare is primary.); employers of 20 or more persons cannot discriminate against employees age 65 or over in the provision of health benefits; and the benefits offered to these persons must not differ from those offered to younger employees;
2. When a beneficiary is covered under the employer group health plan of a working spouse;
3. When a disabled beneficiary is covered under a large employer group health plan (A large employer group health plan is a plan of an employer of more than 100 employees.);
4. When a person is eligible for Medicare because of end-stage renal disease (permanent kidney failure) and has coverage under an employer group health plan—in this situation, Medicare is secondary only during the beneficiary's first 18 months of Medicare eligibility. During this period, Medicare is secondary both when the beneficiary has coverage under an employer group health plan and when the beneficiary is covered under an employer group health plan as a dependent. After the 18-month period expires, Medicare is the primary payer, and the employer group health plan is the secondary payer; or
5. When a beneficiary is covered under an automobile, no-fault, or liability insurance policy.

In these situations, after the primary insurer pays up to its coverage limits, Medicare reimburses the beneficiary for remaining covered services.

The MSP provisions apply to a relatively small portion of the total number of Medicare-eligible persons. The U.S. General Accounting Office (GAO) has estimated that approximately 1.5 million Medicare beneficiaries—approximately five percent—have other insurance that is primary to Medicare. Nevertheless, because of the size of the Medicare program, the dollar value of Medicare claims subject to the MSP provisions is substantial.

It is the first two categories listed above, the so-called "working aged" and their spouses, who make up the bulk of beneficiaries covered by the MSP provisions. The difficulties contractors have in assuring that Medicare does not pay when an employer group health plan is primary are principally due to the problems contractors have in identifying the Medicare beneficiaries who fall in these categories.

Reasons for Subcommittee Review

The Congress has for some time been aware of the difficulties that Medicare contractors face in identifying beneficiaries who (or whose spouse) are covered by an employer group health plan. There is no single Federal data base that identifies Medicare bene-

ficiaries, their spouses, and their employment status. To address this concern, section 6202 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) required a data match of Internal Revenue Service (IRS), Social Security Administration (SSA), and HCFA records. When completed, this data match will identify Medicare beneficiaries who were employed or who had an employed spouse. Employers will then be contacted by HCFA to determine if the beneficiary (or spouse) was covered under an employer group health plan. This effort should enhance HCFA's ability to identify erroneous payments. OBRA 1989 authorized the data match for only two years. The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) extended the authorization through September 30, 1995.

The Office of Management and Budget (OMB) and HHS have been aware of weaknesses in the MSP program. They have identified the MSP program as a high-risk area. The absence of adequate internal controls to assure the collection of timely and accurate information on the insurers of Medicare beneficiaries who are liable as primary payers was included among the material internal-control weaknesses reported to the President and the Congress under the Federal Managers' Financial Integrity Act for both fiscal years 1989 and 1990. The HHS Inspector General has estimated that there are annual Medicare overpayments of between $400 million to $1 billion because of the failure to identify primary payers. In testimony before the Senate last year, the HHS Assistant Secretary for Management and Budget estimated that there may be as much as $1 billion annually in potential secondary payments that are currently unidentified.

GAO has similarly reported that Medicare contractors were not fully realizing potential savings that could be achieved from the implementation of the MSP provisions. In GAO's January 23, 1991 report to the Committee, in response to our request for information on the efficiency and effectiveness of Federal programs within the Committee's jurisdiction, GAO included the MSP program as an area deserving further oversight and review. In testimony before the Subcommittee on Health on June 14, 1990, GAO estimated that the amount of identified Medicare overpayments, nationwide—that is, payments made by contractors, but for which they had subsequently identified another insurer as having potential primary payment responsibility—totaled $200 million. On January 25, 1991, GAO issued a report to HCFA analyzing the inventory of claims of one Medicare contractor. GAO found that Blue Cross and Blue Shield of Maryland (which serves both as the intermediary for Part A claims and as the carrier for Part B claims) had through its MSP investigative efforts developed information showing that claims totaling $8.8 million had been paid for beneficiaries with other health insurance that might be primary. GAO reported that little was being done to recover these funds.

Subcommittee Investigation and Hearing

The Subcommittee on Oversight held a hearing on February 26, 1991, on the MSP provisions. The hearing came at the close of a seven-month investigation by Subcommittee staff and GAO, which included visits to contractor facilities, interviews of contractor and

agency personnel, and examination of agency and contractor documents, in Maryland, Arizona, Nevada, California, Pennsylvania, and Florida. In addition, the HHS Inspector General has conducted audits of MSP reviews of Medicare carriers in Massachusetts, Florida, Indiana, Texas, Colorado, and Missouri. Witnesses representing HCFA, the HHS Office of Inspector General, GAO, and Blue Cross and Blue Shield of Maryland appeared at the Subcommittee hearing. The Subcommittee used GAO's report on the backlog of cases at the Maryland contractor as a case study of MSP problems. Witnesses at the hearing described the way that contractors have implemented the MSP provisions and presented their views on how this process might be improved.

Enactment of the MSP provisions, beginning in 1980, has resulted in significant changes in the way that providers and Medicare contractors handle Medicare claims. Providers were required under Part A (or requested under Part B) to screen beneficiaries about coverage under employer group health plans. Contractors were given two principal functions. First, they are responsible for prepayment screening of Medicare claims to determine whether another insurer is primary. Second, they are responsible for recovering erroneous payments, i.e., claims paid by Medicare which should have been paid by another primary payer.

PROVIDER IDENTIFICATION OF PRIMARY PAYMENT SOURCES

HCFA has established procedures for contractors to identify primary payment sources. The first line of defense in identifying MSP situations is screening by Medicare providers. HCFA requires Part A providers (hospitals, home health agencies and skilled nursing facilities) to interview Medicare beneficiaries when they seek services to determine if Medicare coverage is primary or secondary. HCFA has developed a series of model questions to be asked at the time of admission to determine whether the beneficiary is employed and has health insurance coverage under an employer group health plan, or whether the beneficiary is covered under the employer group health plan of a working spouse. Hospitals and other Part A providers are required to retain screening forms in their files, so that Medicare intermediaries can monitor their compliance with the screening requirements.

When a hospital discovers that a Medicare beneficiary is covered under an employer group health plan, the hospital is required to send the bill to the private insurer. Once a hospital has identified that a Medicare beneficiary covered by the MSP provisions, has submitted a bill to a private insurer for in-patient services, and has received payment, the hospital is required to send the Medicare carrier a "no-pay" bill indicating that another insurer is primary and has paid the bill.

For Part B claims, providers (physicians and suppliers) are requested—although not required—to screen beneficiaries, when they seek services, about other insurance coverage. The HHS Inspector General recommended that Part B providers should, like hospitals, be required to screen for other insurance. The current Part B claim form submitted by physicians (Form HCFA–1500) contains a block (Block 9) for any information the provider may have obtained

about other insurance coverage. (See Attachment #2.) There is, however, no space for information about coverage under a spouse's employer group health plan. Moreover, if no information about other insurance appears on the claim form, the carrier processing the claim has no guarantee that the beneficiary has been questioned about other insurance. On December 10, 1990, OMB approved for use a revision of Claim Form 1500. (See Attachment #3.) The revised form, in development since 1986, will go into use in September, 1991. It will provide more information about whether a beneficiary (or spouse) is covered by other insurance. The new form asks, "Is there another health benefit plan?" and has "yes" and "no" check-off boxes for the response. While this revision may be an improvement, the HHS Inspector General recommended that this question be further clarified to ask: "Do you or your spouse have health insurance coverage through an employer group health plan?" Since the revised Form 1500 needs to be reapproved by OMB for use after December 31, 1991, additional changes and classifications could be made at that time.

Witnesses indicated that hospitals have generally done a better job than physicians in screening for other insurance coverage. However, the Subcommittee is aware of instances where providers repeatedly sent bills to Medicare when they were aware of other primary insurance, instances where bills were routinely sent both to Medicare and to private payers (double billing), instances where hospitals regularly failed to submit "no pay" bills, instances of repeated incorrect billing coding that indicates that Medicare is primary, and other examples of inappropriate billing practices. For example, a hospital had instructed its employees to indicate on Medicare claim forms that the beneficiaries were unemployed so that the contractor would not query the beneficiaries about employer provided health insurance. Currently, when a contractor learns of inadequate screening to identify primary payment sources or of inappropriate billing practices, the contractor is relatively powerless to compel improvement. Civil monetary penalties are not available to the HHS Inspector General in such situations. The Subcommittee believes that civil monetary penalties should be available when a provider has knowingly and willfully engaged in repeated instances of inappropriate MSP billing activities, or repeated failures to obtain MSP information from beneficiaries.

CONTRACTOR IDENTIFICATION OF PRIMARY PAYMENT SOURCES

In addition to the information from provider screening, contractors also have access to data bases which may provide additional information about primary coverage. First, SSA's Master Beneficiary files identify Medicare beneficiaries that are working. For claims by these working beneficiaries, contractors research—"develop," in the parlance of Medicare—the claims to determine if the beneficiary's employer offered group health insurance. (The Master Beneficiary files provide no information about the employment of beneficiaries' spouses.) Second, since December 17, 1990, contractors have been sharing information about MSP situations on a series of regional data bases known as the Common Working File.

Contractors are required, prior to payment, to send all claims to this data base for validation with Common Working File records.

When a contractor receives information that a beneficiary has primary coverage under an employer group health plan, an indicator of primary insurance coverage is added to the Common Working File. Any subsequent claims filed with other contractors in the same region will be matched against this file. For example, when a carrier has entered information in the Common Working File that a beneficiary's claim for physician services under Part B was covered by other primary insurance, this information will then be available to an intermediary if the beneficiary subsequently submits a claim for hospital services under Part A. Claims should be denied (or at least further "developed") when the Common Working File indicates the existence of other primary coverage. When other insurance is primary, the beneficiary is informed that after the employer group health plan has processed the claim for primary benefits, a claim for secondary Medicare benefits may be filed for services not covered by the primary insurance.

HCFA also requires contractors to query beneficiaries about other insurance coverage when the beneficiaries file their first Medicare claim. The Common Working File notifies contractors whenever a claim is the first one submitted by a beneficiary. After paying the claim, the contractors write the beneficiary to determine if the claimant or the claimant's spouse is covered under an employer group health plan. The contractors inform the beneficiary that any subsequent Medicare claims will not be paid until the beneficiary has responded to the contractor's inquiry about other insurance. If a beneficiary does not respond within 30 days, a second letter is sent. If no reply to the follow-up letter is received within 30 days, subsequent claims are suspended until the beneficiary responds. This process is called "first-claim development." (These procedures are somewhat different for disabled beneficiaries and for beneficiaries with permanent kidney failure; for these beneficiaries, subsequent claims are paid even if no response to the first-claim development letter has been received.)

The Subcommittee believes that the first-claim development process is inefficient, and unnecessarily time consuming and paper intensive. Since only about five percent of Medicare beneficiaries are subject to the MSP provisions, witnesses testified that this effort is not well targeted. At the Maryland contractor, for example, affirmative responses—i.e., responses indicating the existence of other primary insurance coverage—are received in response to only 2–3 percent of the hundreds of first-claim development letters sent out every week. Moreover, when, through the first-claim development process, a beneficiary with other primary insurance is identified, Medicare (having already paid the first-claim) is in a "pay-and-chase" posture. Witnesses at the hearing were unanimous in the opinion that it is more efficient to identify primary insurance before the payment of claims than to have contractors "pay-and-chase."

Furthermore, the first-claim development process may be unnecessarily confusing for Medicare beneficiaries. In most instances, it is usually the provider—not the beneficiary—who has submitted the Medicare claim. Accordingly, the beneficiary may not have a

frame of reference when he or she receives an inquiry about a Medicare claim that someone else submitted. In addition, this process "punishes" the wrong person. Currently, HCFA policy provides that subsequent Medicare claims will not be processed until the contractor has received a response to the first-claim development letter. While it is the beneficiary who has failed to respond, it is the provider whose check is delayed.

Witnesses suggested that, as an alternative to first-claim development, beneficiaries be screened about primary insurance when they first enroll in the Medicare program. All the witnesses agreed that it is advantageous for contractors to have information about primary insurance before payment of claims. The Subcommittee believes that screening for other primary insurance could best be accomplished when beneficiaries enroll in the Medicare program.

RECOVERY OF ERRONEOUS PAYMENTS

In addition to identifying primary payment sources while processing claims, Medicare contractors also have the responsibility for recovering amounts paid by Medicare which should have been paid by a primary insurer. Once the Common Working File has received an indication that Medicare is the secondary payer for a beneficiary, an automatic search of that beneficiary's payment history file is conducted to identify any previous Medicare claims that may have been paid erroneously. A list of these claims is placed in a folder and becomes a "case." An individual case may involve several, perhaps hundreds, of claims. For example, GAO provided one instance where a contractor had identified a beneficiary as having other insurance that was potentially primary. For this one beneficiary, Medicare, during a two-year period, had paid 153 separate claims totaling almost $42,000. (See Attachment #4.)

When a case of erroneous payments has been identified, HCFA requires contractors to take steps to recover the amounts incorrectly paid. For Part A hospital claims, intermediaries seek recovery from the hospital that submitted the claim. The intermediary informs the hospital that the contractor's records indicate that Medicare may not be the primary payer. The contractor's letter requests the hospital to determine whether the beneficiary (or spouse) is employed and covered under the group health plan of an employer with 20 or more employees. Unless the hospital responds within 45 days, indicating that the employer group health plan is not primary, the Medicare claim is denied, the amount of the claim is deducted from the intermediary's subsequent payment to the hospital, and the hospital seeks payment from the primary insurer.

To recover for erroneous payments of supplementary medical insurance benefits under Part B, carriers follow a different procedure. Unlike intermediaries, they do not seek repayment from the provider. Instead, carriers write a recovery letter to the insurer of the employer group health plan (or the third-party administrator or employer, if the plan is self-insured or self-administered). The letter explains the contractor's reasons for believing that the employer group health plan is primary. The employer group health plan is given up to 90 days to refund the Medicare payment. If no response is received within 90 days, the carrier sends the employer

group health plan a formal demand for payment. If no response to this letter is received within 60 days, the carrier is instructed to forward the case to the HCFA regional office for possible court action. Accordingly, Part B providers have up to 150 days to respond to carriers' requests for recovery. Witnesses testified that employer group health plans often wait until the last minute to repay claims and demand copies of all documentation pertaining to the claim.

The Subcommittee believes that recovery efforts for Part B claims are plagued with problems. In its report on the inventory of claims to be recovered by the Maryland contractor, GAO reported that Blue Cross and Blue Shield of Maryland had identified 3,059 cases of payments, totaling $8.7 million, where another payer had been identified as potentially primary. For almost half ($4.1 million) of the mistaken payments, it was the private insurance business of Blue Cross and Blue Shield of Maryland which had been identified as having primary payment responsibility. (See Attachment #5.) In four of the ten largest cases, Blue Cross and Blue Shield of Maryland was identified as the primary payer; in two of these cases the mistaken Medicare payments totalled more than $100,000 each. (See Attachment #6.) The Subcommittee is concerned that this situation reflects a possible conflict of interest for Medicare contractors. The HHS Inspector General estimated that, nationwide, twenty percent of identified erroneous payments are the obligations of contractors' private insurance business.

At the time GAO's report was issued, Blue Cross and Blue Shield of Maryland had done little to recover the mistaken payments it had identified. By the time of the hearing, cases totaling $3.5 million had been resolved. Of this amount, $2.7 million had been recovered; for the remaining claims of $800,000, it was determined that Medicare was in fact primary. At the hearing, Blue Cross and Blue Shield of Maryland stated that it was continuing its efforts to resolve the Part A cases listed in GAO report. Blue Cross and Blue Shield of Maryland was not working any Part A cases other than those listed in GAO's report, and its Part B casework had ceased altogether. Representatives of the Maryland contractor attributed this decline in recovery efforts to budget cuts.

The failure (or inability) to resolve cases of erroneous payments appears to be a problem for carriers nationwide. GAO stated that the carriers it had surveyed had essentially stopped trying to make recoveries of Part B erroneous payments. Of seven Medicare contractors surveyed by the HHS Inspector General's office, five reported that they were not conducting any MSP recovery activities. In some ways, Blue Cross and Blue Shield of Maryland had surpassed other contractors' efforts, because it had made efforts to identify mistaken payments. Other contractors were not even identifying potential mistaken payments.

The witnesses attributed contractors' inability to seek to recover erroneous payments to budget cuts. For fiscal year 1988, the contractor budget for MSP activities was $66.9 million. This figure rose to $69.9 million for fiscal year 1989, but fell to $62.3 million in fiscal year 1990, and to $61.3 million for fiscal year 1991. These cutbacks resulted in reductions in the number of employees devoted to the recovery of erroneous payments. The HHS Inspector General

stated that staff devoted to MSP operations at the seven carriers it surveyed, fell from 127 in 1989 to 48 in 1990. Blue Cross and Blue Shield of Maryland stated that the 1990 budget cuts resulted in the elimination of seven case workers, leaving only 1.5 workers. Prior to these budget cuts, contractors were reviewing cases of $50 or more where there was an indication of other insurance. After the budget cuts, this threshold was raised to $250. Even with this increased tolerance level, carriers have not been able to maintain their recovery efforts. For fiscal year 1992, the Administration has requested a budget of $70 million.

CONTRACTOR REPORTS ON MSP ACTIVITIES

HCFA establishes MSP savings goals for each Medicare contractor. The contractors' management information systems accumulate and report to HCFA monthly data regarding savings realized under the MSP provisions. These monthly reports include both "cost avoided" and "cost recovered" savings. Cost avoided savings are those realized when a claim has been denied because the contractor has discovered the existence of other primary insurance. (Intermediaries also treat amounts reported to them on hospital "no pay" bills as cost avoided savings.) Cost recovered savings are those realized when Medicare discovers that it has erroneously paid a claim and recovers this payment from the provider or from the beneficiary's insurer. Contractors reported MSP savings of $750 million in fiscal year 1985; $1.1 billion in fiscal year 1986; $1.45 billion in fiscal year 1987; $1.88 billion in fiscal year 1988; $2.18 billion in fiscal year 1989; and, $2.48 billion in fiscal year 1990.

While contractors report monthly MSP savings to HCFA, they do not regularly report on their inventories of post-payment cases for which they have identified another payer as primary, but for which they have not made recovery. Because of this lack of information, it is impossible to state with precision, the total dollar value of erroneous payments that have been identified by the Medicare contractors and that are potentially due back to the Medicare program. This lack of information frustrated GAO's investigation regarding carrier backlogs. In addition to its examination of the backlog of potentially erroneous claims identified by the Maryland contractor, GAO had undertaken efforts to examine backlogs of erroneous Medicare payments at contractors in California, Florida, Nevada, and Arizona. When it examined the Maryland contractor's backlog of mistaken payments, GAO was able to analyze the claims on a handwritten list the contractor had prepared. No comparable list summarizing the backlog of identified mistaken payments was available at other contractors, and GAO could only examine a sample of claims to predict the extent of mistaken payments. At seven carriers inspected by the HHS Inspector General, claims that had been identified as potential mistaken payments were stored in boxes and file cabinets. None of the carriers could estimate the value of these claims.

HCFA recently attempted to survey Medicare contractors regarding backlogs of unrecovered mistaken payments, but GAO felt that the results of the survey were unreliable. The lack of data regarding the extent of overpayments makes it difficult, if not impossible,

for HCFA to oversee and monitor contractor recovery efforts. GAO recommended that contractors should be required to maintain management information on the number of mistaken payments made and the dollar value potentially due to Medicare.

EVALUATION OF CONTRACTOR MSP ACTIVITIES

HCFA evaluates Medicare contractors under the Contractor Performance Evaluation Program (C-PEP). Contractors are accountable to HCFA on separate performance measures. The maximum score attainable under C-PEP is 1,000, both for carriers and intermediaries. For intermediaries, 100 of the 1,000 points relate to the carrier's application of the MSP provisions. Intermediaries are separately evaluated in the achievement of their annual MSP savings goals and on the success of their efforts to prevent inappropriate billings to the Medicare program. There is not, however, a separate performance standard judging their efforts to recover erroneous Medicare payments. For carriers, 80 of the 1,000 points relate to the MSP provisions. The carrier is evaluated on the achievement of its savings goals, but, again, there is no separate standard evaluating carriers' efforts to recover incorrect Medicare payments.

IRS/SSA/HCFA DATA MATCH

HCFA presented testimony regarding its progress in implementing the IRS/SSA/HCFA data match authorized by OBRA 1989. Thus far, HCFA has requested data for persons who were Medicare beneficiaries during the years 1987-1989. SSA has produced a listing (by Social Security number) of all individuals entitled to Medicare from 1987 to 1989. This listing was provided to the IRS, and run against tax filing information to determine each beneficiary's marital status and to produce a listing of beneficiaries and their spouses (and their Social Security numbers).

The IRS listing of beneficiaries and spouses was then returned to SSA to be matched against the Master Earnings file, and to produce a listing of the Medicare-eligible persons for whom Forms W-2 were submitted, as well as the employers submitting the Forms W-2. This final listing (identifying 16 million persons and 800,000 different employers) identifies those Medicare-eligible persons and their spouses who may have been employed and who may, therefore, have had primary coverage under an employer group health plan.

Using this listing, HCFA will contact the employers to determine if the Medicare beneficiary (or spouse) had health insurance. HCFA expects to begin contacting employers in June, 1991. Employers will be asked to respond, back to 1983 if appropriate, regarding periods of employment and health insurance. If the employers do not respond within 30 days, they face the possibility of a fine of $1,000 per listed individual. (HCFA has indicated that it will routinely grant employers one 30-day extension.) When an employer responds, indicating that a beneficiary (or spouse) was covered under an employer group health plan, this information will be matched against HCFA's Medicare Automated Data Retrieval System (MADRS) to identify all instances of potentially mistaken pay-

ments. This information will then be forwarded to contractors across the country to begin recovery efforts.

The HHS Inspector General testified that this data match will create a retrospective way of identifying beneficiaries with other primary insurance, as well as identifying previous erroneous payments. The information to be produced from the data match pertains to years 1987–1989. It will not be current and, therefore, will be of limited utility for identification of beneficiaries with other primary insurance in the future. It is likely that many of the beneficiaries who had insurance during the years covered by the data match may have retired and will no longer be covered by an employer group health plan.

When HCFA begins to identify additional erroneous payments as a result of employer responses to the questionnaires, contractors will have to undertake increased recovery efforts. For contractors, the recovery efforts will be time consuming and labor intensive. These efforts also may be burdensome for insurers and employers, who may have to retrieve data from inactive or archived data bases.

When the data-match process is completed, contractors, who already have backlogs of cases of erroneous payments to be recovered, will be even further backlogged in their recovery efforts. Moreover, HHS Regulations (42 CFR 411.24(f)) limit the time in which a contractor must initiate a recovery effort to a period of 15 to 27 months after the contractor has identified an erroneous payment. Although HCFA indicated that it hoped to be able to make recoveries of all past mispayments, GAO reported that, with present funding levels for MSP activities, contractors will not be able to achieve recoveries for cases identified by the data match, and that millions of dollars in mistaken payments may not be recovered. The Subcommittee believes that a recovery incentive program, allowing contractors to retain a portion of the erroneous payments they recover, would encourage contractors to achieve greater savings from the overpayments identified as a result of the data match.

Recommendations and Findings

1. Better Identification of Primary Payment Sources

A. Pre-enrollment questionnaire regarding other health insurance coverage. The Subcommittee recommends that HCFA survey Medicare beneficiaries regarding employer group health insurance and spousal coverage by means of an MSP questionnaire to be completed prior to, or at the time of, enrollment in the Medicare program. The Subcommittee believes that the most effective way to prevent erroneous Medicare payments (and to implement the MSP provisions) is by the earliest possible identification of beneficiaries with other primary insurance. If beneficiaries with employer group health insurance are identified prior to the performance of services, the bill can be initially directed to the proper payer. So that this recommendation can be quickly implemented, HCFA should be given authority to use a Medicare contractor to develop the questionnaire to avoid time-consuming procurement rules. The Subcom-

mittee believes that a pre-enrollment questionnaire will render the first-claim development process unnecessary.

B. Improved provider screening of beneficiaries. The Subcommittee recommends that Medicare contractors not make Part B Medicare payments until they have received a claim form with an indication that the provider has screened the beneficiary about other insurance. For Part B claims, HCFA currently recommends, but does not require, that providers screen beneficiaries for other insurance. The Subcommittee recommends that this screening be mandatory. The new Medicare Claim Form 1500 for Part B services, which goes into use later this year, has "yes" and "no" check-off boxes after the question "Is there another health benefit plan?" When there is no entry in this block, HCFA should instruct contractors to suspend payment of claims until this information has been received. (HCFA should make an exception for disabled beneficiaries and beneficiaries with kidney failure, but should require contractors to further "develop" those claims immediately.)

Moreover, the Subcommittee does not believe that the new Claim Form 1500 is sufficiently explicit, especially with regard to coverage under a spouse's employer group health plan. The Subcommittee recommends that HCFA should further amend and clarify Claim Form 1500 to contain the following question: "Do you have health insurance as a result of your, or your spouse's, current employment?"

The Subcommittee believes that the combination of pre-enrollment screening and improved provider screening (as recommended in A and B above) will enable contractors to devote resources to the recovery of erroneous payments, rather than to the first-claim development process. The Subcommittee also believes that a combination of pre-enrollment screening and improved provider screening will make future data matches unnecessary.

C. Sanctions for inappropriate MSP billing activity. The Subcommittee recommends that the HHS Secretary be given the authority to impose sanctions in instances where he can establish a pattern of inappropriate billing practices such as double billing, repeated failures to screen beneficiaries for other insurance coverage, repeated submissions to Medicare of bills that should be submitted to another payer, and repeated failures to submit "no pay" bills. Currently, HHS does not have the authority to impose a civil monetary penalty when a provider has knowingly and willfully engaged in repeated instances of inappropriate Medicare Secondary Payer billing or repeated failures to obtain MSP information from patients. The HHS Secretary should be given authority to impose civil monetary penalties, up to $2,000 per instance of inappropriate billing, in these situations. The Subcommittee believes that such sanctions would be the most effective way to reach providers who repeatedly refuse to accept the responsibility for proper MSP billing. In addition, HCFA should require contractors to identify providers who most frequently submit erroneous claims or fail to inquire about other insurance. As a pre-condition to the imposition of a penalty, HCFA must notify these providers, in writing, that it is monitoring their MSP billing and screening practices and that a civil monetary penalty could be imposed if the provider does not show some improvement.

2. Improved Recovery Efforts

A. Quarterly contractor reports of recovery activities. The Subcommittee recommends that HCFA require contractors to track their efforts to recover erroneous payments and to submit quarterly reports to HCFA regarding these efforts. HCFA should consult with GAO and the HHS Inspector General in determining the data required to be reported, to ensure that sufficient information is collected to give a complete picture of contractor backlogs and recovery efforts. The Subcommittee believes that, at a minimum, these reports should reflect: the number of claims for which other insurers have been identified as primary, the dollar value of those claims, the efforts undertaken by the contractor to recover for the erroneous payment, and the date by which the contractor must begin to undertake recovery efforts.

The Subcommittee believes that this reporting requirement is necessary in order for HCFA to oversee contractor recovery efforts effectively and efficiently. In addition, these reports should enable contractors to maximize savings from collection efforts for erroneous payments that will be identified as a result of HCFA/SSA/IRS data match. The Subcommittee also believes that this reporting requirement will be useful in evaluating future budget requests for MSP activities.

B. Evaluation of contractor recovery efforts. The Subcommittee recommends that HCFA establish a separate C-PEP performance standard to evaluate Medicare contractors on the basis of the number of post-payment cases they have resolved. Currently, HCFA sets MSP savings goals for Medicare contractors which may be realized through the identification of cost-avoided savings rather than actual recovery of erroneous payments. Identification of cost-avoided savings (such as those reflected on "no-pay" bills) is substantially easier for contractors than undertaking efforts to recover erroneous payments. Contractors have few incentives to recover erroneous payments. The Subcommittee believes that a separate performance standard for contractor recovery efforts will result in needed focus on these efforts.

C. Shorter recovery period for recent claims. The Subcommittee recommends that HCFA streamline the process for recovering erroneous payments due from private insurance, or post-payment cases. The Subcommittee believes that for claims relating to services performed within one year, the time period primary insurers are given to respond to carriers' demands for payment should be shortened from 150 to 90 days. The Subcommittee recognizes that there is justification for allowing a longer period to collect older claims, including erroneous payments identified from the IRS/SSA/HCFA data match. Resolving these claims may require locating and searching for archived records, or even contacting an insurer other than the one who currently insures the beneficiary. For more recent claims, however, the Subcommittee believes that private insurers' examination of current records could be completed more quickly than the currently allowed period of 150 days.

3. Funding for MSP activities

A. Adequate funding for MSP activities. The Subcommittee recommends support for the Administration's fiscal year 1992 budget request of $70 million for MSP activities. Of the three payment safeguard activities undertaken by Medicare contractors—medical reviews, provider audits, and MSP—the MSP program is the most cost-efficient, realizing savings of approximately $35 for every dollar invested. Accordingly, the Subcommittee believes that additional MSP funding above prior fiscal year levels is a sound investment.

The Subcommittee also believes that the contractors must have adequate resources to undertake the additional recovery efforts that will ensue from the IRS/SSA/HCFA data match. After a contractor identifies a claim as one for which another payer is primary, the contractor has a limited time in which to initiate recovery efforts. The Subcommittee is concerned that the potential savings to be realized from the erroneous payments identified as a result of the IRS/SSA/HCFA data match may be lost unless contractors have sufficient personnel to handle these additional recovery efforts expeditiously.

B. Study of incentive program to enhance carrier recovery efforts. The Subcommittee recommends that within six months HHS develop and submit to the Committee a plan for an MSP incentive program, under which carriers would be allowed to retain a percentage of the erroneous Medicare payments they recover to finance their MSP activities. The Subcommittee believes that such an incentive program must contain safeguards so that carriers are not induced to relax their pre-payment efforts to identify MSP activities, and so that they cannot benefit by making an erroneous payment and subsequently retaining a portion of a recovered payment. A similar plan has been adopted for third-party reimbursements to the Veterans Administration. OBRA 1990 established a Department of Veterans' Affairs Medical-Care Cost Recovery Fund. Amounts recovered from third-party medical recovery activities are deposited in this fund and are available for further billing and collection activities.

4. Study of contractor eligibility requirements

The Subcommittee recommends that HHS study the appropriateness of allowing entities other than health insurance companies to serve as Medicare contractors. This study should include an analysis of the advantages and disadvantages of such a change, and the recommendations of HHS in this area.

Since the inception of the Medicare program, only health insurance companies have been eligible to contract with the Federal Government as intermediaries and carriers. The Subcommittee is concerned that the MSP provisions have created a conflict of interest for contractors. In many instances, it is the private insurance business of the contractor which is the primary payer for claims subject to the MSP provisions. No comparable conflict of interest exists for contractors which do not maintain health insurance businesses.

ATTACHMENT #1

STATUTORY CHANGES TO THE MSP PROVISIONS

The Omnibus Reconciliation Act of 1980 (effective December 5, 1980) made Medicare secondary to coverage under automobile, no-fault, or liability insurance.

The Omnibus Budget Reconciliation Act of 1981 (effective January 1, 1982) made Medicare secondary to employer-sponsored group health insurance for persons with kidney failure during the first 12 months of Medicare eligibility.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (effective January 1, 1983) made Medicare secondary to employer-sponsored group health insurance, if the working beneficiary or his or her working spouse is age 65, but under 70 years old and is working for an employer with 20 or more employees.

The Deficit Reduction Act of 1984 (DEFRA) (effective January 1, 1985) removed TEFRA's lower age limit for a working spouse.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (effective May 1, 1986) eliminated TEFRA's upper age limit.

The Omnibus Budget Reconciliation Act of 1986 (effective January 1, 1987) made Medicare secondary to employer-sponsored group health insurance for disabled Medicare beneficiaries (and spouses) working for large employers.

The Omnibus Budget Reconciliation Act of 1990 (effective January 1, 1991) extended from 12 to 18 months the period during which employer-provided group health insurance is the primary payer for Medicare beneficiaries with kidney failure.

The MSP provisions are found in Section 1862(b) of the Social Security Act and codified at 42 U.S.C. Sec. 1395y(b) et seq..

ATTACHMENT #2

CURRENT PART B CLAIM FORM
(Form HCFA-1500)

PLEASE DO NOT STAPLE IN THIS AREA"

[redacted]

FORM APPROVED OMB NO. 0938-0008

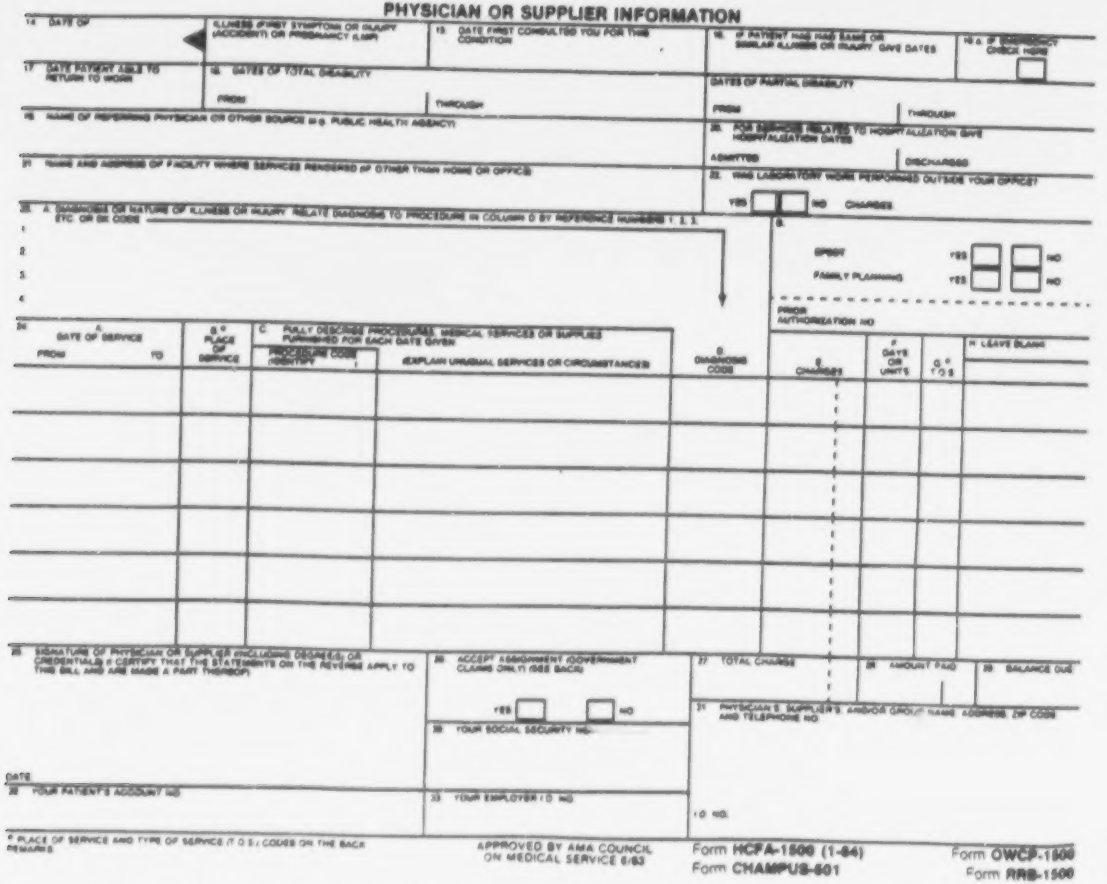
HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

☐ MEDICARE (MEDICARE NO.)	☐ MEDICAID (MEDICAID NO.)	☐ CHAMPUS (SPONSOR'S SSN)	☐ CHAMPVA (VA FILE NO.)	☐ FECA BLACK LUNG (SSN)	☐ OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX: MALE ☐ FEMALE ☐	6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE. INCLUDE ALL LETTERS)
	7. PATIENT'S RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.) ☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
TELEPHONE NO.		
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT: YES ☐ NO ☐ B. ACCIDENT: AUTO ☐ OTHER ☐	11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NO. 11a. CHAMPUS SPONSOR'S STATUS: ACTIVE DUTY ☐ RETIRED ☐ DECEASED ☐ BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW. SIGNED DATE		13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW. SIGNED (INSURED OR AUTHORIZED PERSON)



PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES
16.a. IF EMERGENCY CHECK HERE
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO CHARGES

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR 9X CODE
1.
2.
3.
4.

B. EPSDT YES NO
FAMILY PLANNING YES NO
PRIOR AUTHORIZATION NO

24. A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. * TOS	H. LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES) OR CREDENTIALS (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
DATE
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES NO
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO
32. YOUR PATIENT'S ACCOUNT NO
33. YOUR EMPLOYER I.D. NO.
I.D. NO.

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK REVERSE

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (1-84)
Form CHAMPUS-501
Form OWCP-1500
Form RRB-1500

ATTACHMENT #5

PRIVATE INSURANCE COMPANIES WITH POTENTIAL PAYMENT RESPONSIBILITY FOR ERRONEOUS MEDICARE PAYMENTS MADE BY THE MARYLAND MEDICARE CONTRACTOR (BLUE CROSS/BLUE SHIELD)

Dollars in thousands

Insurer	Cases	Part A	Part B	Total
Blue Cross/Blue Shield of MD	1,553	$2,867	$1,243	$4,110
Aetna Life and Casualty	157	369	107	476
Blue Cross/ Blue Shield of D.C.	81	258	33	291
Columbia Freestate	42	206	34	240
Connecticut General	127	202	104	306
Prudential Insurance Company of America	93	197	67	264
Travelers Insurance Co.	102	167	105	272
Metropolitan	78	128	54	182
Lincoln National	41	124	33	157
Equitable Life Assurance Society	63	124	47	171
Carefirst	30	117	27	144
Willse & Associates	101	114	90	204
Blue Cross/Blue Shield of Pa.	8	110	25	135
Total	2,476	$4,983	$1,969	$6,952

ATTACHMENT #6

TEN LARGEST MEDICARE CASES THAT SHOULD BE RECOVERED BY MARYLAND CONTRACTOR

Insurer	Part A Dollars	Part A Claims	Part B Dollars	Part B Claims	Total Dollars	Total Claims
Blue Cross/Blue Shield of Maryland	124,591.41	5	12,290.82	50	136,882.23	55
Blue Cross/Blue Shield of Maryland	97,419.02	19	11,118.31	68	108,537.33	87
Blue Cross/Blue Shield of Pennsylvania	83,082.00	27	8,339.30	93	91,421.30	120
I.L.A Benefit Fund	62,351.83	4	9,607.36	29	71,959.19	33
Columbia Freestate	67,661.51	20	1,644.27	59	69,305.78	79
Blue Cross/Blue Shield of Maryland	59,118.66	78	7,377.07	79	66,495.73	157
Carefirst	54,912.38	7	10,764.46	62	65,676.84	69
Blue Cross/Blue Shield of Maryland	57,732.01	7	71.12	3	57,803.13	10
Mass Mutual	49,212.20	9	7,702.91	62	56,915.11	71
Columbia Freestate	44,730.10	5	4,947.61	0	49,677.71	5
Total	700,811.12	181	73,863.23	505	774,674.35	686

ATTACHMENT #3

REVISED PART B CLAIM FORM

PLEASE DO NOT STAPLE IN THIS AREA

BAR CODE AREA

PROPOSED REVISION 10-88

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM in ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self / Spouse / Child / Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single / Married / Other; Employed / Full-Time Student / Part-Time Student	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY, GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES / NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO If yes, return to and complete item 9 a-d.

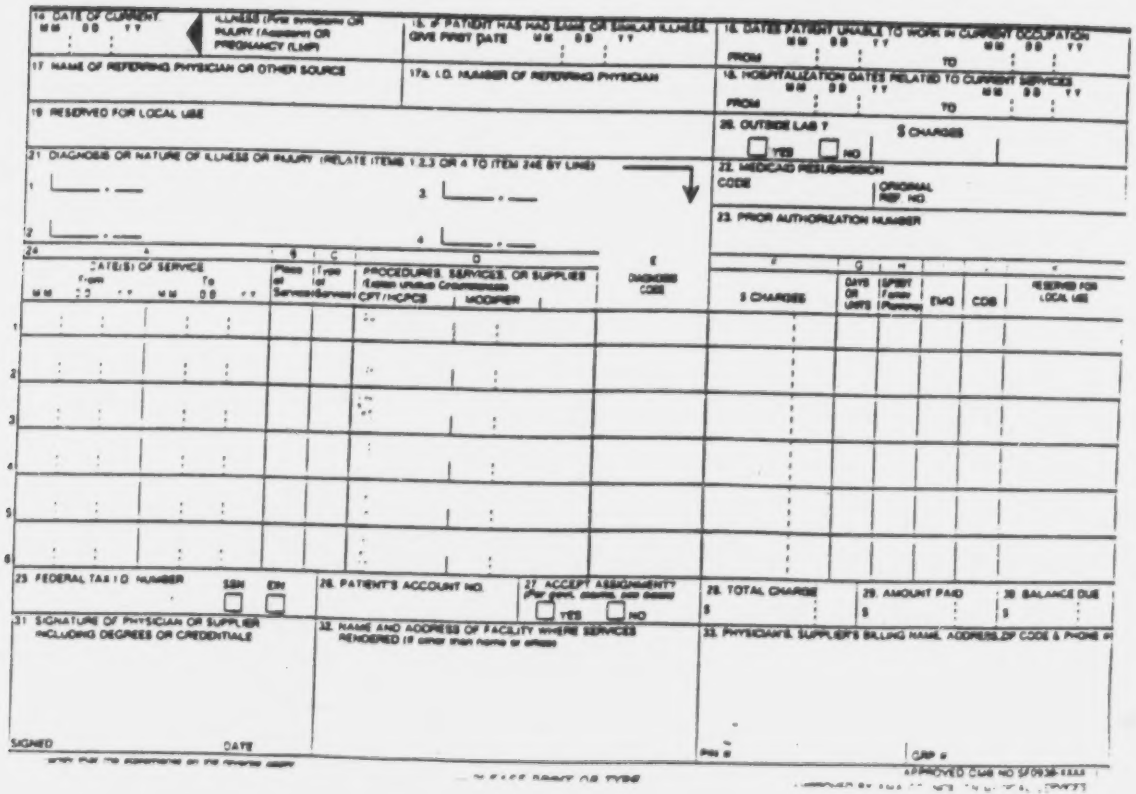
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____



14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom OR) INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — MM DD YY — FROM — TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — MM DD YY — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB ? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1 . 2 . 3 . 4 .

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN # GRP #

SIGN THE REVERSE OF THE FORM

PLEASE PRINT OR TYPE

APPROVED OMB NO. 0938-0008

EXAMPLE OF $41,776.00 IN POTENTIALLY ERRONEOUS PAYMENTS MADE ON BEHALF OF ONE MEDICARE BENEFICIARY IN 1989 AND 1990

1)	5902601	12/27/89	$58.39
2)	9911547	10/13/90	$121.84
3)	10924618	12/12/89	$15.71
4)	11901120	01/02/90	$56.86
5)	11901243	01/04/90	$19.74
6)	11922987	12/12/89	$1,580.47
7)	16621570	12/14/89	$1,307.89
8)	16621571	01/04/90	$9.58
9)	17924382	12/20/89	$12.87
10)	18370340	11/21/89	$23.30
11)	18936805	01/08/90	$56.86
12)	18936989	01/11/90	$19.74
13)	19605480	01/12/90	$2.94
14)	25672950	01/19/90	$189.39
15)	25918382	01/16/90	$56.86
16)	25918496	01/18/90	$19.74
17)	26924297	12/15/89	$113.18
18)	29773130	12/18/89	$159.32
19)	32929298	01/22/90	$48.51
20)	32929524	01/25/90	$19.74
21)	38910996	10/13/89	$13.15
22)	399.4054	01/29/90	$56.86
23)	46931551	02/08/90	$50.51
24)	48017590	12/12/89	$788.75
57)	122625250	04/23/90	$43.38
58)	122625260	04/20/90	$189.83
59)	122922819	01/31/90	$102.85
60)	127518330	05/01/90	$33.22
61)	128318470	12/15/90	$442.47
62)	136323170	04/30/90	$31.55
63)	143689170	10/20/89	$5,205.18
64)	143689180	11/20/89	$4,758.41
65)	143689190	12/20/89	$6,027.14
66)	143689200	01/20/90	$5,440.63
67)	143689210	02/20/90	$1,193.22
68)	166505870	05/31/90	$31.55
69)	166606280	06/02/89	$90.00
70)	176528730	06/04/90	$327.51
71)	176915982	06/04/90	$598.58
72)	176916329	06/15/90	$100.02
73)	178907579	06/03/90	$89.90
74)	178907580	06/02/90	$68.59
75)	180663510	06/02/90	$54.58
76)	180903153	06/08/90	$12.44
77)	183722500	06/18/90	$209.19
78)	186781380	06/23/90	$400.24
79)	201663380	06/30/90	$54.58
80)	201663390	07/02/90	$54.58
112)	9243929681	08/24/89	$17.60
114)	9249435760	08/25/89	$29.20
115)	9264468460	09/18/89	$40.00
116)	9270912174	06/06/89	$319.60
117)	9275723910	09/22/89	$624.92
118)	9294548040	10/06/89	$52.00
119)	9286929628	10/03/89	$26.35
120)	9296466800	06/06/89	$103.04
121)	9299933767	10/06/89	$758.64
122)	9299934282	10/14/89	$72.00
123)	9300914831	10/05/89	$128.75
124)	9303364300	10/14/89	$54.24
125)	9303364310	10/16/90	$27.12
126)	9303364311	10/17/89	$79.66
127)	9306909204	10/26/89	$12.75
128)	9307929213	10/13/89	$13.15
129)	9312936913	10/11/89	$183.44
130)	9313800570	10/03/89	$3.00
131)	9314802660	11/03/89	$39.16
132)	9320914713	10/30/89	$51.69
133)	9320914714	11/02/89	$21.31
134)	9320924447	11/06/89	$69.11
135)	9325448030	10/19/89	$232.49
136)	9331935418	11/13/89	$58.39

251	54923233	02/12/90	$48.51
261	54923452	02/15/90	$19.74
271	57349110	10/03/89	$420.88
281	57349111	10/17/89	$108.17
291	59318540	02/16/90	$123.41
301	59318550	02/16/90	$27.41
311	60917440	02/20/90	$33.43
321	60917574	02/23/90	$26.90
331	64427390	02/27/90	$4.79
341	64486810	02/01/90	$53.11
351	64486870	02/14/90	$70.49
361	67824790	12/12/89	$86.16
371	67930603	02/26/90	$48.51
381	67930793	03/01/90	$16.78
391	68590940	01/31/90	$25.75
401	72620560	03/08/90	$16.94
411	72916280	03/05/90	$39.16
421	74311070	03/12/90	$65.60
431	74919854	03/05/90	$31.65
441	74920109	03/08/90	$34.83
451	79417170	02/26/90	$31.33
461	79501510	01/31/90	$231.39
471	81387270	03/16/90	$53.70
481	81927438	03/12/90	$23.31
491	82369100	03/20/90	$28.29
501	85352400	03/19/90	$409.41
511	96622760	04/04/90	$4.82
521	106485100	01/31/90	$488.84
531	109931107	04/13/90	$34.86
541	110315580	04/13/90	$72.03
551	121901980	04/17/90	$120.31
561	122475790	01/31/90	$242.81
811	201663400	07/04/90	$81.88
821	201663410	07/09/90	$109.17
831	204900570	06/17/90	$67.21
841	204927829	07/09/90	$145.53
851	208911535	07/02/90	$12.44
861	213902067	06/26/90	$135.67
871	214370290	07/23/90	$214.80
881	214924630	07/23/90	$34.99
891	214924856	07/26/90	$19.88
901	215920300	07/16/90	$33.66
911	215920306	07/19/90	$39.28
921	221924730	07/30/90	$27.09
931	221924965	08/02/90	$32.80
941	9160910039	05/17/90	$51.30
951	9166915811	06/02/89	$53.13
961	9170323190	06/02/89	$3.00
971	9172929774	06/09/89	$61.97
981	9174385660	05/31/89	$47.36
991	9177362990	06/02/89	$28.00
1001	9178631150	06/12/89	$54.24
1011	9178631160	06/10/89	$27.12
1021	9179918429	06/09/89	$19.60
1031	9180431270	06/08/89	$147.12
1041	9181929813	06/20/89	$300.40
1051	9188922443	06/20/89	$87.07
1061	9192923249	06/26/89	$54.24
1071	9193380450	05/31/89	$1,337.20
1081	9193624140	07/03/89	$3.00
1091	9193921928	06/23/89	$191.73
1101	9202942837	07/03/89	$38.30
1111	9208911165	06/21/89	$407.76
1121	9213910421	06/20/89	$63.20
1371	9333878040	11/27/89	$87.80
1381	9333913898	11/03/89	$116.02
1391	9334788570	10/09/89	$245.52
1401	9334925146	11/20/89	$58.39
1411	9340409030	11/30/89	$31.33
1421	9340912821	11/13/89	$232.03
1431	9341927463	11/27/89	$38.34
1441	9341927631	11/30/90	$17.23
1451	9343870940	11/16/89	$78.33
1461	9347896330	10/09/89	$135.76
1471	9347909531	11/17/89	$33.99
1481	9348900434	12/04/89	$58.39
1491	9348900639	12/07/89	$10.94
1501	9353604970	12/11/89	$39.16
1511	9355917516	11/09/89	$20.27
1521	9363620330	12/12/89	$150.15
1531	9363938612	12/06/89	$49.84
			$41,776.80